HOSPITAL ADMISSIONS CERTIFICATION

9505.0500 DEFINITIONS. (Rule 48 effective January 10, 1989)

Subpart 1. Scope. As used in parts 9505.0500 to 9505.0540, the following terms have the meanings given them.

Subp. 2. Admission. "Admission" means the act that allows the recipient to officially enter a hospital to receive inpatient hospital services under the supervision of a physician who is a member of the medical staff.

Subp. 3. Admission certification. "Admission certification" means the determination of the medical review agent that all or part of a recipient's inpatient hospital services are medically necessary and that medical assistance or general assistance medical care funds may be used to pay the admitting physician, hospital, and other vendors of inpatient hospital services for providing medically necessary services, subject to parts 9500.1070, subparts 1, 4, 6, 12 to 15, and 23; 9500.1090 to 9500.1155; 9505.0170 to 9505.0475; 9505.1000 to 9505.1040; and 9505.5000 to 9505.5105.

Subp. 3a. Admitting diagnosis. "Admitting diagnosis" means the physician's tentative or provisional diagnosis of the recipient's condition as a basis for examination and treatment when the physician requests admission certification.

Subp. 4. Admitting physician. "Admitting physician" means the physician who orders the recipient's admission to the hospital and who is a party to a written provider agreement with the department.

Subp. 4a. Authorization number. "Authorization number" means the number issued by the medical review agent that establishes that the surgical procedure requiring a second surgical opinion is medically appropriate.

Subp. 5. Certification number. "Certification number" means the number issued by the medical review agent that establishes that all or part of a recipient's inpatient hospital services are medically necessary.

Subp. 6. Clinical evaluator. "Clinical evaluator" means a person who is employed by or under contract with the medical review agent and who is either licensed by the Minnesota Board of Nursing to practice professional nursing under Minnesota Statutes, section 148.171, or a physician.

Subp. 7. Commissioner. "Commissioner" means the commissioner of human services or an authorized representative of the commissioner.

Subp. 8. Concurrent review. "Concurrent review" means a review and determination performed while the recipient is in the hospital and focused on the medical necessity of inpatient hospital services. The review consists of admission review, continued stay review, and, when appropriate, procedure review.

Subp. 9. Continued stay review. "Continued stay review" means a review and determination, after the admission certification and during a patient's hospitalization, of the medical necessity of continuing inpatient hospital services to the recipient.

Subp. 10. Department. "Department" means the Minnesota Department of Human Services.

Subp. 10a. Diagnostic category. "Diagnostic category" means the list of diagnosis-related groups in the diagnostic

classification system established under Minnesota Statutes, section 256.969, subdivision 2, and defined in part 9500.1100, subpart 20.

Subp. 10b. **Diagnostic category validation or validate the diagnostic category.** "Diagnostic category validation" or "validate the diagnostic category" refers to the process of comparing the medical record to the information submitted on the inpatient hospital billing form required by the department to ascertain the accuracy of the information upon which the diagnostic category was assigned.

Subp. 11. **Emergency.** "Emergency" means a medical condition that if not immediately diagnosed or treated could cause a recipient serious physical or mental disability, continuation of severe pain, or death.

Subp. 12. **General assistance medical care or GAMC.** "General assistance medical care" or "GAMC" means the health services provided to a recipient under the general assistance medical care program according to Minnesota Statutes, section 256D.03, and applicable rules adopted by the commissioner as either may from time to time be amended and enforced.

Subp. 13. **Hospital.** "Hospital" means an institution that is approved to participate as a hospital under Medicare and that is maintained primarily for the treatment and care of patients with disorders other than mental diseases and tuberculosis.

Subp. 14. **Inpatient hospital service.** "Inpatient hospital service" means a service provided by or under the supervision of a physician after a recipient's admission to a hospital and furnished in the hospital for the care and treatment of the recipient. The inpatient hospital service may be furnished by a hospital, physician, or a vendor of an ancillary service which is prescribed by a physician and which is eligible for medical assistance or general assistance medical care reimbursement.

Subp. 15. **Local agency.** "Local agency" means a county or multicounty agency authorized under Minnesota statutes as the agency responsible for determining eligibility for the medical assistance and general assistance medical care programs.

Subp. 16. **Medical assistance or MA.** "Medical assistance" or "MA" means the program established under title XIX of the Social Security Act and Minnesota Statutes, chapter 256B. For purposes of parts 9505.0500 to 9505.0540, "medical assistance" includes general assistance medical care unless otherwise specified.

Subp. 17. **Medical record.** "Medical record" means the information required in part 9505.1800, subpart 3.

Subp. 18. **Medical review agent.** "Medical review agent" means the representative of the commissioner who is authorized by the commissioner to make decisions about admission certifications, concurrent reviews, continued stay reviews, retrospective reviews, and second surgical opinions if such opinions are a term of the agent's contract with the department.

Subp. 19. **Medically necessary.** "Medically necessary" means an inpatient hospital service that is consistent with the recipient's diagnosis or condition, and under the criteria in part 9505.0540 cannot be provided on an outpatient basis.

Subp. 19a. **Medically appropriate or medical appropriateness.** "Medically appropriate" or "medical appropriateness" refers to a determination, by a medical review agent or the department, that the recipient's need for a surgical procedure requiring a second surgical opinion meets the criteria in part 9505.0540 or that a third surgical opinion has

substantiated the need for the procedure.

Subp. 20. **Medicare.** "Medicare" means the federal health insurance program for the aged and disabled under title XVIII of the Social Security Act.

Subp. 21. **Physician.** "Physician" means a person licensed to provide services within the scope of the profession as defined in Minnesota Statutes, chapter 147.

Subp. 22. **Physician adviser.** "Physician adviser" means a physician who practices in the specialty area of the recipient's admitting or principal diagnosis or a specialty area related to the admitting or principal diagnosis.

Subp. 23. **Prior authorization.** "Prior authorization" means the prior approval for medical services by the department as required under applicable rules and regulations adopted by the commissioner.

Subp. 23a. **Principal diagnosis.** "Principal diagnosis" means the condition established, after study, to be chiefly responsible for causing the admission of the recipient to the hospital for inpatient hospital services.

Subp. 23b. **Principal procedure.** "Principal procedure" means a procedure performed for definitive treatment of the recipient's principal diagnosis rather than one performed for diagnostic or exploratory purposes or a procedure necessary to take care of a complication. When multiple procedures are performed for definitive treatment, the principal procedure is the procedure most closely related to the principal diagnosis.

Subp. 23c. **Provider.** "Provider" means an individual or organization under an agreement with the department to furnish health services to persons eligible for the medical assistance or general assistance medical care programs. Providers include hospitals, admitting physicians, and vendors of other services.

Subp. 24. **Readmission.** "Readmission" means an admission that occurs within 15 days of a discharge of the same recipient. The 15-day period does not include the day of discharge or the day of readmission.

Subp. 25. **Recipient.** "Recipient" means a person who has applied to the local agency and has been determined eligible for the medical assistance or general assistance medical care program.

Subp. 26. **Reconsideration.** "Reconsideration" means a review of a denial or withdrawal of admission certification according to part 9505.0520, subpart 9.

Subp. 27. **Retrospective review.** "Retrospective review" means a review conducted after inpatient hospital services are provided to a recipient. The review is focused on validating the diagnostic category and determining the medical necessity of the admission, the medical necessity of any inpatient hospital services provided, the medical appropriateness of a surgical procedure requiring a second opinion, and whether all medically necessary inpatient hospital services were provided.

Subp. 28. **Second surgical opinion.** "Second surgical opinion" means the confirmation or denial of the medical appropriateness of a proposed surgery as specified in parts 9505.5000 to 9505.5105.

Subp. 29. **Transfer.** "Transfer" means the movement of a recipient after admission from one hospital directly to another.

MS s 256B.04 subds 2,15; 256B.503; 256D.03 subd 7 para (b)

9 SR 2296; 11 SR 1687; 13 SR 1688

9505.0510 SCOPE.

Parts 9505.0500 to 9505.0540 establish the standards and procedures for admission certification to be followed by admitting physicians and hospitals seeking medical assistance or general assistance medical care payment under parts 9500.1090 to 9500.1155 for inpatient hospital services provided to medical assistance or general assistance medical care recipients under Minnesota Statutes, chapters 256B and 256D. Parts 9505.0500 to 9505.0540 are to be read in conjunction with Code of Federal Regulations, title 42, and titles XVIII and XIX of the Social Security Act. The department retains the authority to approve prior authorizations established under parts 9505.5000 to 9505.5030 and second surgical opinions established under parts 9505.5035 to 9505.5105. A hospital or admitting physician who seeks medical assistance or general assistance medical care payment for inpatient hospital services provided to a Minnesota recipient must comply with the requirements of parts 9505.0500 to 9505.0540 unless the hospital or admitting physician has received prior authorization for inpatient hospital services under parts 9505.0170 to 9505.0475. Admission certification must be obtained when a recipient moves from one hospital with a provider number to another hospital with a different provider number or from one unit within a hospital to another unit with a different provider number in the same hospital. For purposes of this part, "provider number" means a number issued by the department to a provider who has signed a provider agreement under part 9505.0195.

MS s 256B.04 subds 2,15; 256B.503; 256D.03 subd 7 para (b)

9 SR 2296; 11 SR 1687; 13 SR 1688

9505.0520 INPATIENT ADMISSION CERTIFICATION.

Subpart 1. **Requirement for admission certification.** Except as provided in subparts 2 and 14, an admission providing inpatient hospital service to a recipient must receive admission certification prior to the recipient's admission in order for the admitting physician, the hospital, or other vendor of an inpatient hospital service to receive medical assistance or general assistance medical care program payment for the inpatient hospital service.

Subp. 2. **Exclusions from admission certification or prior admission certification.** Admission for inpatient hospital services under items A to C shall be excluded from the requirement in subpart 1.

A. **Admission** certification is not required before an emergency admission and shall be subject to subpart 4, item B.

B. **Admission** certification is not required for delivery of a newborn or a stillbirth, inpatient dental procedures, or inpatient hospital services for which a recipient has been approved under Medicare. However, if an inpatient hospital service is also covered under Medicare, then denial of the service under Medicare on grounds other than medical necessity shall also constitute sufficient grounds for denying admission certification for the service under medical assistance. The admission of a pregnant woman that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission shall be subject to retroactive admission certification.

C. Admission of a recipient who has been approved by the county for inpatient hospital services for chemical

dependency as specified in parts 9530.6600 to 9530.6655 may occur without admission certification, provided that the inpatient hospital chemical dependency services to the recipient during the recipient's stay in the hospital are not to be billed to medical assistance under parts 9500.1090 to 9500.1155.

Subp. 3. **Admitting physician responsibilities.** The admitting physician who seeks medical assistance or general assistance medical care program payment for an inpatient hospital service to be provided to a recipient shall:

A. Obtain prior authorization from the department for any service requiring prior authorization. Medical assistance and general assistance medical care payment shall be denied when a required prior authorization is not obtained prior to admission.

B. Request admission certification by contacting the medical review agent either by phone or in writing and providing the information in subitems (1) to (9):

(1) hospital's medical assistance provider number and name;

(2) recipient's name, medical assistance or general assistance medical care identification number, and date of birth;

(3) admitting physician's name and medical assistance provider number;

(4) primary procedure code according to the most recent edition of Current Procedural Terminology published by the American Medical Association or the International Classification of Diseases--Clinical Modification, published by the Commission on Professional and Hospital Activities, Green Road, Ann Arbor, Michigan 48105 which are incorporated by reference. These books are available through the Minitex interlibrary loan system and are subject to change;

(5) expected date of admission;

(6) whether the admission is a readmission or a transfer;

(7) admitting diagnosis by diagnostic code according to the most recent edition of the International Classification of Diseases--Clinical Modification; and

(8) information from the plan of care and the reason for admission as necessary for the medical review agent to determine if admission is medically necessary or the procedure requiring a second surgical opinion is medically appropriate; or

(9) when applicable, information needed to prove that a procedure requiring a second surgical opinion meets the criteria for exemption from the requirement.

C. Provide the following information when applicable:

(1) surgeon's name and medical assistance provider number;

(2) expected date of surgery;

(3) affirmation that prior authorization has been received;

(4) affirmation that a procedure requiring a second surgical opinion that was denied by the medical review

agent has been approved by a third physician; and

(5) when requested by the medical review agent, documentation that the procedure requiring a second surgical opinion meets the criteria for exemption from the requirement.

D. Inform the hospital of the certification number.

E. Provide the hospital documentation necessary for the verification required in subpart 4, item D.

F. For purposes of billing, enter the certification number, any required prior authorization number, and second surgical opinion authorization number on invoices submitted to the department for payment.

Subp. 4. **Hospital responsibilities.** A hospital that seeks medical assistance or general assistance medical care payment for inpatient hospital services provided to a recipient shall:

A. Obtain the certification number and the authorization number, if required under parts 9505.5000 to 9505.5105, from the admitting physician.

B. Within 48 hours after the occurrence of an event described in subitem (1) or (2), and within 72 hours of the event described in subitem (3), excluding weekends and holidays, inform, by phone, the medical review agent of the event and provide the information required in subpart 3, items B and C, if applicable.

(1) An admission that is an emergency admission as specified in subpart 2.

(2) A surgical procedure requiring a second surgical opinion that meets the requirements of part 9505.5040, item B or C, for exemption from the second opinion.

(3) The admission of a pregnant woman that does not result in the delivery of a newborn or a stillbirth within 24 hours of her admission, as specified in subpart 2, item B.

For purposes of this subitem, the time limit for notifying the medical review agent is calculated beginning with the time of the admission of the pregnant woman.

If the hospital fails to notify the medical review agent within the required time limit, the hospital shall submit, at its own expense, a copy of the complete medical record to the medical review agent within 30 days after the recipient's discharge. Failure to submit the record within the 30 days shall result in denial of the certification number.

C. For billing purposes, enter the certification number and any required prior authorization number and second surgical opinion authorization number on all invoices submitted to the department for payment.

D. Within 20 days, exclusive of weekends and holidays, of the date of a written request by the medical review agent, obtain and submit to the medical review agent an admitting physician's verification that a procedure requiring a second surgical opinion has been approved by a third physician. The verification must include at least the signed form required by the department to approve a procedure requiring a second surgical opinion.

Subp. 5. **Retroactive eligibility.** A hospital may seek admission certification for a person found retroactively eligible for medical assistance or general assistance medical care program benefits after the date of admission. The hospital

shall inform the admitting physician of the admission certification number of a retroactively eligible recipient. An admitting physician and a hospital shall not seek admission certification for a person whose application for the medical assistance or general assistance medical care program is pending. The medical review agent may require the hospital to submit, at its own expense, a copy of the complete medical record to substantiate the medical necessity of the admission. Failure to submit a requested record within 30 days of the request shall result in denial of admission certification.

Subp. 6. **Medical review agent responsibilities.** The medical review agent shall:

A. obtain and review the information required in subpart 3, items B and C, if applicable;

B. determine within 24 hours of receipt of the information, exclusive of weekends and holidays, whether admission is medically necessary, whether a surgical procedure requires a second surgical opinion or is exempt from the requirement, and whether a procedure requiring a second surgical opinion meets the criteria of appropriateness established in part 9505.0540 or requires the approval of a third physician;

C. inform the admitting physician and the hospital of the determination, by phone, within 24 hours of receipt of the information, exclusive of weekends and holidays;

D. mail a written notice by certified letter of the admission certification determination to the admitting physician and the hospital, and a written notice to the recipient within five days of the determination, exclusive of weekends and holidays;

E. determine if admission of a retroactively eligible recipient was medically necessary and if the surgical procedure requiring a second opinion was medically appropriate;

F. conduct a concurrent, continued stay, or retrospective review of a recipient's medical record as specified in subpart 10;

G. provide for a reconsideration of a denial or withdrawal of admission certification, and of an authorization number denied or withdrawn under subpart 8, item C;

H. recruit and coordinate the work of the physician advisers;

I. notify the admitting physician and the person responsible for the hospital's utilization review, by phone, of a reconsideration decision within 24 hours of the decision, exclusive of weekends and holidays;

J. mail a written notice by certified letter of the reconsideration decision to the admitting physician, the person responsible for the hospital's utilization review, and the department within ten days of the determination, exclusive of weekends and holidays;

K. provide for consideration of a request for retroactive admission certification;

L. validate the diagnostic category; and

M. perform other duties as specified in the contract between the medical review agent and the department.

Subp. 7. **Ineligibility to serve as physician adviser.** A physician shall not be eligible to serve as a physician adviser

if:

A. the physician is the admitting physician; or

B. during the previous 12 months, the physician issued treatment orders or participated in the formulation or execution of the treatment plan for the recipient for whom admission certification is requested; or

C. the physician and the physician's family, which means the physician's spouse, child, grandchild, parent, or grandparent, has an ownership interest of five percent or more in the hospital for which admission certification is being requested; or

D. the physician can obtain a financial benefit from the admission of the recipient.

Subp. 8. **Procedure for admission certification or authorization of surgical procedure requiring a second surgical opinion.** The procedure for admission certification or authorization of a surgical procedure requiring a second surgical opinion shall be as in items A to H.

A. Upon receipt of the information requested in subpart 3, items B and C, if applicable, the clinical evaluator shall review the information and determine whether the admission is medically necessary or whether a procedure requiring a second surgical opinion is appropriate or meets the criteria for exemption from the requirement.

B. If the clinical evaluator determines that one of the conditions in item A exists, the medical review agent shall issue a certification or authorization number.

C. If the clinical evaluator determines that a procedure requiring a second surgical opinion does not meet the criteria for exemption under part 9505.5040, except items B, C, and F, the medical review agent shall notify the admitting physician by phone and mail the admitting physician and the recipient a written notice within 20 days of the determination. If the exemption is denied, the recipient who wants the surgery may obtain a second or third surgical opinion. Exemptions from the second surgical opinion under part 9505.5040, items B and C, shall be subject to subpart 4, item B. Exemptions from the second surgical opinion under part 9505.5040, item F, shall be subject to part 9505.5096, subpart 4. If the medical review agent determines that the procedure requiring a second surgical opinion was not entitled to an exemption or that the surgical procedure was not medically appropriate under part 9505.5040, items B, C, and F, the medical review agent shall not issue or shall withdraw the authorization number and notify the admitting physician and the hospital of denial of the authorization number. The notice shall be in writing, mailed by certified letter within 20 days of the determination, and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

D. If the clinical evaluator is unable to determine that the admission is medically necessary or that a procedure requiring a second surgical opinion is appropriate, the evaluator shall contact a physician adviser.

E. If the physician adviser determines that the admission is medically necessary or that a procedure requiring a second surgical opinion is appropriate, the medical review agent shall issue a certification or authorization number.

F. If the physician adviser is unable to determine that the admission is medically necessary or that a procedure

requiring a second surgical opinion is appropriate, the physician adviser shall notify the clinical evaluator by phone, the clinical evaluator shall notify the admitting physician by phone, and the admitting physician may request a second physician adviser's opinion, except in the case of a procedure requiring a second surgical opinion. In this case, the medical review agent shall notify the admitting physician that the recipient may obtain the opinion of a third physician as provided in parts 9505.5050 to 9505.5105.

G. If the admitting physician does not request a second physician adviser's opinion, the medical review agent shall deny the admission certification, shall not issue a certification number, and shall notify the admitting physician, the hospital, and the recipient of the denial. The notice to the recipient shall be in writing and shall state the reasons for the denial and the recipient's right to appeal under Minnesota Statutes, section 256.045, and part 9505.0522. The notices to the admitting physician and the hospital shall be in writing, shall state the reasons for the denial, and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

If the admitting physician requests a second physician adviser's opinion about an admission, the clinical evaluator shall contact a second physician adviser.

H. If the second physician adviser determines that the admission is medically necessary, the medical review agent shall issue a certification number.

I. If the second physician adviser is unable to determine that the admission is medically necessary, the medical review agent shall deny the admission certification, shall not issue a certification number, and shall notify the admitting physician, the hospital, and the recipient of the denial. The notice to the recipient shall be in writing and shall state the reasons for the denial and the recipient's right to appeal under Minnesota Statutes, section 256.045, and part 9505.0522. The notices to the admitting physician and the hospital shall be in writing and shall state the reasons for the denial and shall state that the admitting physician or the hospital may request reconsideration of the denial under subpart 9 or may directly appeal the denial under Minnesota Statutes, chapter 14.

Subp. 9. **Reconsideration.** The admitting physician or the hospital may request reconsideration of a decision to deny or withdraw an admission certification or an authorization number under subpart 8, item C. The admitting physician or the hospital shall submit the request in writing to the medical review agent together with the recipient's medical record and any additional information within 30 days of the date of receipt of the certified letter denying or withdrawing admission certification or the authorization number. Upon receipt of the request, the medical record, and any additional information, the medical review agent shall appoint at least three physician advisers, none of whom shall have been involved previously in the procedure for the recipient's admission certification or authorization number, to hear the reconsideration. The reconsideration may be conducted by means of a telephone conference call. The physician advisers may seek additional facts and medical advice as necessary to decide whether the admission is medically necessary or whether the surgical procedure requiring a second surgical opinion meets the criteria of exemption or is medically appropriate under part 9505.5040, items B, C, and F. The reconsideration shall be completed within 45 days of the receipt of the information necessary to complete the reconsideration. The outcome of the reconsideration shall be the one chosen by the majority of the physician advisers appointed to consider the request. The

admitting physician or the hospital may appeal the determination of the physician advisers according to the contested case provisions of Minnesota Statutes, chapter 14, by filing a written notice of appeal with the commissioner within 30 days of the date of receipt of the certified letter upholding the denial or withdrawal of admission certification or authorization number. However, an admitting physician or hospital that does not request reconsideration or appeal under the contested case procedures of Minnesota Statutes, chapter 14, within 30 days after the denial or withdrawal of admission certification or authorization number is not entitled to an appeal under Minnesota Statutes, chapter 14.

Subp. 9a. **Retention or withdrawal of certification number.** When a hospital discharges a recipient who is subsequently readmitted to the same or a different hospital or transfers a recipient to another hospital, the readmission or transfer is subject to the procedures in part 9505.0540, subparts 3 to 6. The hospital or admitting physician who disagrees with the medical review agent's determination under this subpart may request reconsideration as specified in subpart 9.

Subp. 10. **Medical record review and determination.** As specified in the contract between the department and the medical review agent, upon the request of the department, or upon the initiative of the medical review agent, the medical review agent shall conduct a concurrent, continued stay, or retrospective review of a recipient's medical record to validate the diagnostic category and to determine whether the admission was medically necessary, whether the inpatient hospital services were medically necessary, whether a continued stay will be medically necessary, whether all medically necessary services were provided, or whether a surgical procedure requiring a second opinion was medically appropriate. The procedure for concurrent, continued stay, and retrospective reviews shall be as in items A to G.

A. A clinical evaluator shall review the medical record and may review the bills, invoices, and all supporting documentation pertaining to a request for medical assistance and general assistance medical care payment.

B. If the clinical evaluator is unable to determine that the recipient's admission was medically necessary, that the recipient's continued stay will be medically necessary, or that all medically necessary services were provided, the clinical evaluator shall request additional information from the admitting physician or the hospital as necessary to clarify the medical record.

C. If, after additional information is submitted, the clinical evaluator is unable to determine that the recipient's admission was medically necessary, that the recipient's continued stay will be medically necessary, or that all medically necessary services were provided, a physician adviser shall be consulted.

D. If a physician adviser determines that the recipient's admission was not medically necessary, that the recipient's continued stay will not be medically necessary, or that all medically necessary services were not provided, the medical review agent shall withdraw the previously issued certification number and shall notify the admitting physician and hospital by telephone within 24 hours of the determination and by certified letter mailed within five days, exclusive of weekends and holidays, of the determination. The notice shall state the right of the admitting physician and hospital to request a reconsideration or appeal under subpart 9.

E. If the diagnostic category validation shows that